Mr. John F. Tighe
Deputy to the Governor for Health Policy
Deputy Commissioner of Finance and Administration
Tennessee Department of Finance and Administration
706 Church Street
5th Floor Doctor's Building
Nashville, TN 37247-0492

Dear Mr. Tighe:

We are pleased to inform you that your request to approve the new TennCare Demonstration Project (No. 11-W-00151/4) for five years, from July 1, 2002, through June 30, 2007 has been approved. Approval of this project is granted under the authority of section 1115 of the Social Security Act (the Act).

Our approval of this demonstration and the waivers and Federal matching provided thereunder, is contingent upon compliance with the enclosed Special Terms and Conditions (STCs). This approval is also subject to our receiving your written acceptance of the STCs within 30 calendar days from the date of this letter. Approval of this demonstration does not dispose of any issues currently pending investigation by the Office of Civil Rights.

The methodology for calculating budget neutrality for the new demonstration shall be as specified in Attachment B to the STCs.

List of Sections Waived

Under the authority of section 1115(a)(1) of the Act, the following waivers of State plan requirements contained in section 1902 of the Act are granted to enable Tennessee to carry out the TennCare demonstration through this period:

1. Amount, Duration and Scope of Services Section 1902(a)(10)(B)

   To enable the State to modify the Medicaid benefit package to: a) offer a different benefit package than would otherwise be required under the State plan; b) to offer benefits for such individuals without offering the same coverage to the non-demonstration population; and, c) to limit benefits offered to individuals who elect the TennCare Assist program to payment of part or all of the cost of coverage under a group health plan.

2. Uniformity — Section 1902(a)(1)

To enable the State to provide certain types of managed-care plans only in certain geographical areas of the State and to permit non-demonstration populations, e.g., those requiring long-term-care, to receive current Medicaid benefits, whereas demonstration recipients will receive modified services.

3. Eligibility — Section 1902(a)(34)

To enable the State to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made.

4. Freedom of Choice — Section 1902(a)(23)

To enable the State to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans that would not be consistent with the requirements of section 1932 of the Act.

5. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Benefit — Section 1902(a)(10)

To enable the State to permit managed care contractors to limit coverage of FQHC and RHC services when CMS and the State have determined that equivalent services are available and accessible in other covered settings.

6. Disproportionate Share Hospital (DSH) Payments — Section 1902(a)(13)(A)

To relieve the State from the obligation to make payments for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients.

7. Payment for Drugs — Section 1902(a)(54)

To enable the State to permit managed care contractors to establish drug formularies based on cost, therapeutic equivalent and clinical efficacy.

8. Indirect Payment — Section 1902(a)(32)

To enable the State to pay indirectly for covered benefits through a group health plan that meets requirements set by the State and approved by CMS.

Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of the project, be regarded as expenditures under the State's Title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditures, except those waived above and those specified below as not applicable to these expenditure authorities. In addition, all requirements in the enclosed STCs will apply to these expenditure authorities.

1. Expenditures for the following demonstration populations who would not be eligible under the approved State plan. These populations may be automatically disenrolled after a year in the absence of a reapplication and redetermination of eligibility.

    - individuals who are uninsured and meet the State defined criteria as "medically eligible,"

    - individuals who are uninsured with family income at or below 200% of the Federal Poverty Level (FPL),

    - children under age 19, with family income at or below 200% FPL, who were enrolled in the previous demonstration as of December 31, 2001 under the category of "uninsured who had access to insurance,"

    - individuals who have Medicare coverage but not Medicaid coverage, were enrolled in the previous demonstration as of December 31, 2001, and continue to meet the criteria for "Uninsurable" that were in place at that time (whose coverage under this demonstration will be limited to pharmacy benefits), and

    - enrollees in the TennCare Assist program who would otherwise be eligible in one of the categories above (whose benefits under this demonstration will be limited to employee health insurance subsidy payments).

2. Expenditures under contracts that do not meet the requirements in section 1903(m) specified below. Specifically, Tennessee managed-care plans will be required to meet all requirements of section 1903(m) except the following:

    - 1903(m)(2)(A)(vi), 42 C.F.R. 434.27, to the extent that the rules in section 1932(a)(4) incorporated therein are inconsistent with the enrollment and disenrollment rules under the demonstration such as restricting an enrollees' right to disenroll within 90 days of enrollment in a new MCO. Enrollees may change managed care organizations once

within the first year of enrollment, and annually thereafter, except that during initial transition enrollment, enrollees may be limited to one change during the first enrollment period which may be less than12 months but no less than 6 months.

3. Expenditures for services to a TennCare enrollee residing in an Institution for Mental Disease for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days and other limitations specified in the STCs.

Your project officer for this project is Joseph Millstone, who can be reached at (410) 786-2976. Communications regarding program matters should be submitted to the project officer at the following address: Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, 7500 Security Boulevard, S2-01-16, Baltimore, Maryland 21244-1850.

We extend our congratulations on this award and look forward to working with you on this innovative project.

Sincerely,

Thomas A. Scully
Administrator

Enclosure